

**North Carolina  
State Child Fatality Review Report  
SFY 06-07  
G.S. 143B-150.20**

**Family Support and Child Welfare Services Section  
Division of Social Services  
North Carolina Department of Health and Human  
Services**

**2007**

**Report to the General Assembly  
From the State Fatality Review Team**

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## **State Child Fatality Review Report - SFY 06-07**

### **Executive Summary**

The Department of Health and Human Services, Division of Social Services, is charged in N.C.G.S. 143B-150.20 with the responsibility of convening a State Child Fatality Review Team to “conduct in-depth reviews of child fatalities that have occurred involving children and families involved with local Departments of Social Services Child Protective Services in the 12 months preceding the fatality.” The purpose of these reviews is to “implement a team approach to identifying factors which may have contributed to conditions leading to the fatality and to develop recommendations for improving coordination between local and State entities which might have avoided the threat of injury or fatality and to identify appropriate remedies.” The statute specifies team membership that includes representatives from the Division of Social Services and the local Department of Social Services (DSS), a representative from the local Community Child Protection Team (CCPT), a representative from the local Child Fatality Prevention Team (CFPT), a representative from local law enforcement, a medical professional, and a prevention specialist.

The fatality review process is a lengthy one, usually spanning over two full days. The process consists of interviews with selected individuals who have knowledge of the child and family and review of case records from the local DSS and other agencies that provided services to the child and his/her family. The process focuses attention on the role and involvement of the broader community in protecting children, e.g. the review is not just about local DSS actions. At the conclusion of each review, a formal report is issued which includes findings and recommendations from the State Child Fatality Review Team. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to the public upon request. Following the issuance of each report, staff from the Division of Social Services (the Division) presents the recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each state level recommendation.

Reviews and final reports are not necessarily completed during the SFY in which the fatality occurs. During SFY 06-07, eight (8) final fatality review reports were issued following completion of the reviews; in addition, there were 23 fatality reports listed as pending completion. Of the 8 reports released, 4 of these were for child fatalities reported in SFY05-06. During the 06-07 fiscal year, there were 104 deaths reported to the Division of Social Services. Of the 104 deaths reported, the Division identified 31 child fatality cases that met the criteria for an intensive State Child Fatality Review. Sibling groups are counted as one case. One of the fatalities included a sibling group of two children and another fatality involved a sibling group of three children, which gives a total 34 child deaths. Of the 31 cases that met the criteria for an intensive review, neglect was suspected to have contributed to the fatality in 20 cases and abuse was suspected in 8 cases. In the remaining 3 cases, the cause of death was undetermined. Of the 20 neglect related deaths, 3 resulted in criminal charges. All of the 8 abuse cases resulted in criminal charges.

For the reviews conducted during the year, the review teams identified six major themes. First, the review teams identified the need for the local Department of Social Services (DSS) to improve in the area of compliance with policy and best practice. In an effort to assist local DSS agencies with improvement, there were a variety of recommendations made for the Division and local DSS agencies. Secondly, mental health issues were prevalent during this period. This

particular theme involved fragmentation in mental health services. At times, these services are unavailable or not provided at an affordable cost to clients. The third major theme was insufficient subsidized child care. Themes four through six include safe sleeping/co-sleeping issues, non-compliance with the reporting law, and under-utilization of voluntary support services.

Additional themes and issues were identified and are listed in Appendix A to this report. Appendix B lists accomplishments by local communities as a result of recommendations from reviews.

## **State Child Fatality Review Team Annual Report**

Pursuant to G.S. 143B-150.20, the following is the State Child Fatality Review Team annual report to the N.C. General Assembly for SFY 06-07. This report includes a summary of findings and recommendations from child fatality reviews conducted by the State Child Fatality Review Teams during SFY 06-07. These teams conduct multidisciplinary reviews when there is suspicion that neglect or abuse contributed to a child's death and the local DSS Children's Services Program was involved with the child or family at any time during the 12 months prior to the child's death.

### **I. History**

In 1997, the General Assembly enacted G.S. 143B-150.20 and established the State Child Fatality Review Team to conduct in-depth reviews of any child fatalities which have occurred involving children and families involved with local Departments of Social Services' Child Protective Services in the 12 months preceding the fatality.

The collaborative, multi-disciplinary approach to these reviews, along with information available to the public through the review reports, allow these reviews to be learning tools for the entire community as well as teach us how we can improve our efforts to prevent future child deaths.

Feedback from those involved with State Child Fatality Review Teams has been that there is ownership by the local communities with Review Team recommendations and commitment to implementation of the resulting action plans. The State Child Fatality Review Teams have implemented six-month follow-up contacts with the local Community Child Protection Teams (CCPT's) after a review is completed. These follow-up contacts with the CCPT's focus on the progress at the local level in implementing any systemic changes as a result of the recommendations from the Review Team.

### **II. Review Process**

Currently, child fatality reviews are conducted as follows:

- A. By State law, anyone who has cause to suspect that a child has died as the result of maltreatment must report the case to the director of the county Department of Social Services (DSS).
- B. Within 5 days of receiving information regarding a child death, the DSS reports to the Division of Social Services (the Division) information that they receive regarding any child who is suspected to have died as a result of maltreatment.
- C. The Division determines whether the necessary criteria are met to invoke a review by a State Child Fatality Review Team based on information from the county DSS and any local law enforcement or health care professional who was involved in investigating the child's death or the death scene.

- D. A State Fatality Review Team is convened, including representatives of the Division, the local DSS, and representatives from the local Community Child Protection Team, the local Child Fatality Prevention Team, local law enforcement, a medical expert, and a prevention specialist.
- E. Division staff on the team begins all reviews with an introduction about the review process to all participants.
- F. The review consists of interviews with selected individuals and review of case records of the local DSS and other agencies that provided services to the child and family. The process focuses attention on the role and involvement of the broader community in protecting children.
- G. The team writes a report that includes the findings of the review and recommendations for system improvement.
- H. The team presents these findings and recommendations in a public meeting of the Community Child Protection Team. The written report is available to the general public, upon request.
- I. As each State Child Fatality Review Report is completed and released, Division staff present recommendations that have statewide impact to the State Child Fatality Prevention Team in an effort to identify the most appropriate state level entity to follow up on each recommendation. Recommendations that need to be addressed by the Division are reviewed by the Family Support and Child Welfare Services Section Management Team for any needed action.

### **III. Facts regarding State Child Fatality Review Process**

The State Child Fatality Review process is an ongoing one, and there is overlap from one fiscal year to the next. Therefore, reviews conducted and reports issued include fatalities that were reported to the Division and decisions to conduct reviews from the previous fiscal year as well as those from the current fiscal year. Some of the cases identified for review in the current fiscal year will be reviewed in the next fiscal year.

During SFY 06-07, the State Division of Social Services identified 31 child fatality cases (out of 104 deaths reported) in 26 counties that met the criteria for a State Child Fatality Review Team review during SFY 06-07. Out of the 31 child fatality cases, 8 final fatality review reports were issued with a remaining 23 fatality reports listed as pending. These 23 reports will be finalized in SFY 07-08. There is a great deal of work involved with finalizing a fatality report, to include a negotiation between members of the state team, legal staff and the district attorney. That being said there is overlap from one year to the next, as the completion of the fatality report process may begin one year and end the following year.

There are two requirements that must be met for a State Child Fatality Review, to include 1) the child and/or family must have been involved with a local Department of Social Services (DSS) Child Protective Services in the 12 months preceding the fatality; and 2) suspicion of parental/caretaker abuse or neglect must be determined by the Division as a

factor in the fatality. Of these 31 fatality cases, neglect was suspected in 20 cases, abuse was suspected in 8 cases and the remaining 3 cases were undetermined.

#### **IV. Fatality Reviews/Major Themes and Actions Taken SFY 06-07**

The State Child Fatality Review Team often identifies similar issues in the cases that are reviewed. At other times, there may be a major issue identified that had not been noted previously, but that has statewide impact. Other findings are more case specific or community specific.

The six most commonly identified major findings and lessons learned from the child fatality reviews completed during SFY 06-07 are summarized herein to allow the Division, local Departments of Social Services, and other state and county agencies to make systemic improvements focused on the safety of children. Achievements at the state level related to these findings are noted where relevant at the time the individual fatality reports were issued.

Appendix A reflects recommendations that were identified less often or that were more case-specific, but that were still important recommendations that should be considered statewide. Appendix B reflects achievements at the local level that have resulted from recommendations from State Child Fatality Reviews.

##### **A. Inconsistent Compliance with Policy and Best Practice**

The inconsistent compliance with policy and best practice was a significant finding in many of the State Child Fatality Reviews across North Carolina during FY 06-07. The reasons for this inconsistent compliance included, inexperienced staff, higher than recommended case loads, and staff turnover. There were also numerous instances where social services staff did not access existing information within their agency, including review of case histories and database queries. On multiple occasions, findings from the reviews illustrated a lack of gathering of pertinent information from other service providers both locally and statewide. The lack of holistic and comprehensive assessments/services to families and children serves as a missed opportunity to address all child safety and well-being needs. It is important to note that staff turnover and high caseloads were found to be contributing factors in many case situations that involve lack of compliance with policy, as well as situations where failure to use best practice was a factor.

In prior years, numerous findings from reviews identified the need to research internal agency history to assist with identifying patterns during the intake process. Access to Administrative Office of the Courts (AOC) records is beneficial in assessing criminal activities and how they may impact on the safety and well being of children. This access has been expanded to all 100 counties to aid in the assessment of risk to children. The Division has implemented policy requiring mandatory criminal record searches as a part of completing a thorough assessment.

Collaboration within local DSS, cross county/jurisdictional cases, and cases where families move across state lines continue to be an area of concern. Several reviews indicated that during an open child protective services case when two or more local Departments of Social Services are involved, services to families can be improved with more effective communication and collaboration between agencies. Improved services would include child and family team meetings to collaborate and communicate with family members and service providers, discussions with licensing workers prior to placement of children in foster homes and then ongoing monthly communication to address additional needs, and joint home visits when cases have been transferred across county lines. To address this issue, the Division formed a workgroup composed of staff from the Division and staff from local Departments of Social Services. The workgroup has completed its work and state policy has been enhanced with the approval of the Jurisdiction in Child Welfare. This policy addresses case situations when families move from one county to another; in addition, situations when multiple local DSS agencies are involved with the same family. The effective date of Jurisdiction in Child Welfare policy was September 2007.

***B. Mental Health Services for Families***

In several counties, mental health reform and the subsequent confusion over where to seek services has been a barrier. Often families must travel out of county to seek mental health and substance abuse services. These services are limited and may not be offered as conveniently as in the past. Requests to re-evaluate the Mental Health Reform are prevalent in many fatality reviews reports. These requests include findings sighting a lack of services and a mental health system that is confusing and difficult for our families to follow and understand. When mental health services are provided, treatment team meetings are required to ensure that the needs of children and families are being addressed. Meetings should occur monthly with all involved parties coming together to discuss the treatment plan, risk factors and ongoing needs. When children are in the custody of the Department of Social Services, there should be ongoing communication between the therapist and the social worker, with notification to the social worker should the client fail to keep appointments or comply with the treatment plan.

***C. Insufficient Subsidized Child Care***

The lack of subsidized child care has been a contributory factor in several child deaths across North Carolina during SFY 06-07. This shortage of child care created a significant barrier for many single parents working in low wage jobs. Records and interviews involving parents in this type of situation revealed that the parents made grossly inappropriate choices in relation to safe and appropriate child care in order to maintain employment.

#### **D. Safe Sleeping/Co-Sleeping Issues**

Over the past fiscal year, a substantial number of infants died as a result of suffocation, mechanical wedging, or asphyxiation in relation to sleeping patterns and practices. These seemingly rising deaths are occurring due to inappropriate bedding in cribs, children sleeping on couches with parents, or being wedged between a mattress and a wall. Recommendations include Community Child Protection Teams (CCPT's) addressing safe sleeping practices and equipment in trainings for social workers and foster parents; and collaborating with community partners to provide training to service providers that have contact with families in the home setting. Many concerns surfaced around young service providers who may not have personal experience on safe sleeping equipment. Training should be focused on how to assess and recognize safe sleeping patterns and sleeping equipment based on developmental stages of children.

The Division of Social Services already offers a variety of training opportunities that would allow instruction on safe sleeping and the use of safe sleeping equipment. For example, Model Approach to Partnership in Parenting (MAPP) training is required by families in order to become licensed foster parents. Instruction on safe sleeping could be incorporated into MAPP.

The Division of Public Health has an established training on safe sleeping. They, in-conjunction with the American Pediatric Society, are strong advocates of the Back to Sleep Campaign. Several recommendations from the fatality reviews are that the Division should partner with existing agencies and support established campaigns that promote the safety and well being of infants while they sleep. It is felt that partnerships should occur at both the state (during trainings) and county levels by continuing to stress the importance of safe sleeping for infants.

#### **E. Non-Compliance with the Reporting Law**

In order to qualify for funding under the Child Abuse and Treatment Act (CAPTA), all states, including North Carolina, have enacted some type of mandatory child abuse and neglect reporting. North Carolina G.S. 7B-301 states: *"Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, ... or has died as a result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found."*

This particular theme regarding the failure of community service professionals as well as citizens to report suspected child abuse and neglect continues to be a significant issue during Intensive Child Fatality Reviews in FY06-07. The information ascertained from the reviews specifies a wide range of reasons for this problem. The biggest factor remains the overall lack of awareness of the mandatory reporting law as defined in G.S 7B-301. While there appears to be an increase in collaboration between local Departments of Social Services and community service providers regarding reporting requirements and procedures, at times some community service providers fail to report. Many community service providers receive brief training or information regarding mandatory reporting, but that training does not appear to be reinforced regularly or routinely.

Information gathered from many fatality reviews indicates that potential reporters are reluctant to make reports of suspected child abuse and neglect as they feel they must have definitive proof or evidence of the maltreatment. The Strengths-based Structured Intake tool was approved by the Children's Services Committee of the North Carolina Association of County Directors of Social Services and implemented by the Division on June 1, 2003. This structured tool was created to allow trained DSS personnel to illicit relevant information and engage reporters. The questions utilized in the structured intake tool allow for a better and more concentrated exchange of information between the reporter and the intake professional by using a specific set of questions, which depending on the information, prompts follow up questions or directs the staff person to another topic. The result is an efficient and informative process which allows the local Departments of Social Services to make informed screening decisions based on the information collected during the intake process.

As in previous years, recommendations from the fatality review teams included the need for additional training in the local communities regarding the requirements for reporting suspected child abuse and neglect, as well as increased public awareness campaigns on how to report suspicions of abuse and neglect. Numerous community service agencies and professionals such as mental health agencies, domestic violence shelters, hospital and emergency room staff, pediatricians, county employees, educational personnel, emergency management staff, and law enforcement agencies were identified as those who could significantly benefit from additional training on recognizing signs of abuse and neglect and on the requirement for reporting suspicions to DSS.

First responders to child fatalities, including Emergency Management Services, local law enforcement, hospital emergency department staff, medical examiners would greatly benefit from additional training and information focusing on the need to make reports to DSS when there is a suspicion of abuse and/or neglect, as well as when a child dies and there are surviving children in the home.

There are current directives in place, specifically Division policy that require all local Departments of Social Services to provide regular community awareness and public education programs on recognizing and reporting abuse, neglect, and dependency. While all counties provide some manner of community awareness and public education programs, these efforts do not appear to be reaching all community members as evidenced by the findings from the review teams.

Prevent Child Abuse North Carolina, along with local efforts, continues to serve a vital role in educating communities and raising public awareness statewide about recognizing abuse and neglect and how to report suspicions to local Departments of Social Services. This organization spends a great deal of resources on the prevention of child abuse and neglect. This is an extremely valuable resource, as many services in the child welfare system are largely reactive services by nature of the involvement following some incident of child abuse or neglect. Prevent Child Abuse North Carolina provides regional training throughout the state for local community educators, child care professionals, and other service providers, which focuses on a wide range of child protection and advocacy issues, including education on the mandatory reporting requirements for suspected child abuse and neglect. Through

their Helpline (1-800-CHILDREN), Prevent Child Abuse North Carolina provides a Prevention Resource Center that has public education and awareness material and training curricula that is available to local CCPT's and CFPT's. This information can be accessed at [www.preventchildabusenc.org](http://www.preventchildabusenc.org).

#### **F. Under-Utilization of Voluntary Support Services**

A common finding in many Intensive Child Fatality Reviews was the under-utilization of voluntary support services by families involved with local Departments of Social Services across North Carolina. While there are wide ranges in both the volume and size of support services throughout the state, each of the one-hundred counties enjoys some level of services that are available to their citizens. One problem reflected in the findings from many fatality reviews was that relevant and beneficial support services were offered to families in a timely manner, and families did not take advantage of the referrals. While social services agencies worked diligently to assess risk to children, there is an inherent need for families to assume a partnership in realizing their own self determination. One common theme was that the voluntary support services in conjunction with other DSS safety measures / mandates would allow families an additional layer of support while working through difficult situations. Social services professionals often reported that the conditions within the family did not meet criteria for court action or court involvement, and in the absence of court involvement, families did not feel compelled to go forward with seeking assistance for voluntary services. In this same theme, the absolute need for families and service providers to form meaningful partnerships is essential if cycles of abuse and neglect are to be addressed. Community service professionals voiced frustration and disappointment regarding the underutilization of voluntary support services

### **V. Conclusion**

The contributions of informed state and community professionals that served on the State Child Fatality Review Teams during SFY 06-07 have made this report possible. These individuals devoted countless hours during the reviews, frequently volunteering their time without compensation. The review team members intensively reviewed the circumstances of each child's death and confirmed that protecting children is a shared community responsibility.

The findings and recommendations of these multidisciplinary teams have statewide implications. It is recommended that state agencies and all local communities in North Carolina use this report to examine the issues relevant to the protection of children and the prevention systems in place in order to make any improvements that are indicated. If the lessons learned as a result of a child's death can be applied in such a way as to prevent future fatalities, the state's protection of children will be significantly enhanced and the legislative intent will be met.

## **Appendix A**

Appendix A reflects additional recommendations that were either identified less frequently than those in the body of the report or that were case specific. These are important recommendations that can be implemented statewide.

### Medical Examiner Issues

- North Carolina needs a Medical Examiner system that disseminates, distributes and applies the science and other information that exists in the central State Medical Examiner's office through every community and county requiring that information.
- A protocol should be developed by the State Medical Examiner's office and regional child abuse experts to rule out possible child abuse prior to ruling SIDS.
- The Medical Examiner's office should complete a thorough death investigation assessment which should include communicating with law enforcement and the emergency management system.
- A trained representative from the Medical Examiner's office should be present at every scene involving a child death.
- Autopsy reports and toxicology screens should be completed in a more timely fashion. Often it takes 6-8 months to receive the final report, this delay may allow for vital crime scene information to be lost.

### Parenting Education/Community Awareness

- Community awareness should be provided regarding the dangers of infants testing positive for illegal substances at birth.
- Every year, children die due to gun related incidents, therefore continued public awareness regarding gun safety and safe storage of fire arms should be provided.
- Collaboration should occur between local Departments of Social Services and local Health Departments to provide SIDS awareness trainings to DSS staff and the community and to support the Back to Sleep Campaign and educate the community regarding the risks of co-sleeping.

### Mental Health

- All 100 counties do not, but should have access or required funding to complete parent capacity assessments.

### Resistant Families in Child Protective Services

- Voluntary parent- initiated child placements should be used when it is a short term solution, the parent will participate and follow through with the case plan and it is not a substitute for bringing a child into DSS custody because of safety issues especially when parents would not participate in the development or follow through with the case plan.
- The Division should review the utilization of safety plans as related to the legal authority to enforce them and provide guidance for county DSS agencies when the plan is not followed. Safety plans should be specific and monitored for compliance. When violation of the safety plan increases risk to the children, supervisors and workers should consult with attorneys regarding petitioning for custody.

- When a case has been opened for a Child Protective Investigative Assessment and a Safety Resource (alternative living arrangement) is still necessary because inappropriate behavior has not changed and safety issues remain if the child were to be returned to the parent, the agency should not substantiate and then close the Child Protective Investigative Assessment until that Safety Resource (alternative living arrangement) is legally secure. The local DSS should petition the court for substantiated Child Protective Services cases and request a court ordered placement when safety issues warrant a Safety Resource (alternative living arrangement).
- When local DSS agencies make a referral for a family, they should follow up with the service provider to see if the family made an appointment or kept an appointment that was made when a child's wellbeing is at stake. The agency should be clear about what the response will be when an agreed upon plan of action is not carried out by the family.
- The Division should continue to provide guidance to local DSS agencies in the form of specific policy, protocols and ongoing training for social workers that encounter resistant families, as this resistance in and of itself greatly elevates the risk to children.
- Kinship care assessment tool does not adequately reflect other children residing in the home. The Division should consider revising this assessment tool to account for such children.

#### School Issues

- Public schools should be more proactive when it comes to attendance. In addition to attendance being important for school achievement, it is also an indicator relating to the child's health and wellbeing. The local CCPT's should hold discussions with their school systems regarding more aggressive enforcement of existing policies including any legal recourse and to better educate the community about the truancy hotline and school options for ensuring school attendance.
- The NC Department of Public Instruction should develop a centralized computer system to track school attendance and to issue an alert if children are withdrawn and not re-enrolled or record request submitted in a reasonable amount of time.
- Schools should utilize community resources when concerns do not rise to the level of abuse, neglect or dependency. School social workers should be well versed on these community resources to provide assistance to teachers in making appropriate referrals.
- Schools usually experience misbehavior/behavior disorders on an early basis and need to ensure that these behaviors are appropriately assessed to identify and evaluate potential treatment.
- Schools should follow procedures set forth in N.C.G.S. 115C-378 regarding the accumulation of 10 unexcused absences in a school year.

#### Division of Social Services and local Departments of Social Services supervisory oversight

- Local DSSs should encourage all agencies to call and discuss with them any case of suspected neglect. Local DSSs also should suggest to agency callers that the CCPT is a resource if the concern exists and it does not meet the criteria for neglect or abuse.
- On-going training should be provided by the Division to social workers regarding chronic illness and medically fragile children as it relates to neglect and abuse.
- Ongoing training should be provided to social workers regarding substance abuse risk factors and domestic violence risk factors. These risk factors should be thoroughly assessed and included in the assessment of risk and the safety assessment.

- Consistent and thorough supervision of front line social workers should ensure all potential victim children are identified and assessed by local DSS management.
- Local DSSs should utilize after-hours workers to monitor supervision of families. County DSS management should remind workers and supervisors of the importance of utilizing after hours workers.
- The local CCPT's should become more of an active resource for the interagency staffing of particularly problematic cases involved with the local Department of Social Services.
- Supervisors of local DSS blended teams should ensure that all cases are staffed a minimum of once a month. Local DSS supervision should include continually evaluating whether new information should be taken as a new report for investigation. Local DSSs should review their agency's mission, goals and the role of supervisors in meeting these goals.
- The local DSS should ensure that a multi-level ongoing accountability and quality improvement plan is in place to assure that CPS protocols are carried out.
- Local DSS supervisors should look at the quality of collateral contacts to ensure that they get the best information possible in order to ensure the protection of children.
- Team meetings should occur anytime that several agencies are involved in the same family. When local DSS is involved they should initiate meetings with various agency personnel and establish roles and responsibilities for all the workers involved with the family. This community team should see that the intervention is tailored to the client to include cultural issues. Local DSS supervisors should ensure team meetings are scheduled as appropriate. Supervisors should consider attending team meetings with inexperienced workers.
- Close attention should be paid to determining who might be able to provide objective information in which to verify parental reports.
- Legal interventions by local DSS should be evaluated when non-compliance of case plans occurs and risk factors remain present.
- It is imperative that DHHS develop a state wide tracking system for families involved in the child welfare system.

#### Medical Issues

- When a local DSS has a medical advisor on staff, staff should ensure that the medical advisor is informed of injuries to children in DSS custody and proper medical attention should be sought to examine such injuries.
- Services for families in rural counties should be enhanced, to include medical care that is readily available and public transportation.
- The North Carolina Medical Board should require training on domestic violence, to include recognition of signs and symptoms of domestic violence to their licensees. All local hospitals should provide ongoing education on how to screen for domestic violence and statutes regarding required reporting.
- The Child Service Coordination program is not fully utilized. Additional attention should be focused on ensuring nights and weekend hospital staff understands the referral process and the importance of these referrals.

#### State Child Fatality Task Force

- The Task Force should investigate other state juvenile laws that impact 16-18 year olds to determine if this age group is classified as adults when crimes are committed. Juveniles

that fall into this age group are treated as adults in some respect and minors in others. It is hard to be consistent when this happens.

#### Access to Consistent Information between County Agencies

- Best practice should be used for sharing information between county agencies, to include providing history and background information on families that are being served by multiple agencies.
- Consistent information should be available to agencies across county lines to include all CPS history as well as history of services provided to families by other units housed under DSS (i.e., Work First, Medicaid, etc.). Counties should be able to access a centralized database that is shared across the state and include information such as the allegations of a report, what was found during a CPS assessment, what services families have received, etc.

## **Appendix B**

Appendix B reflects some of the achievements reported by local communities that resulted from recommendations from State Child Fatality Reviews, as well as preventative measures implemented to prevent future injuries or fatalities.

- A statewide CFPT conference was held in Durham this year which provided information sharing sessions including guest speakers, workshops, and learning materials.
- The initial Cross County Issues Policy, December 2003 has been revised. A workgroup was formed and through a collaborative effort with representatives from local Departments of Social Services and the NC Division of Social Services policy has been enhanced. The revised policy has been renamed Jurisdiction in Child Welfare. This policy is intended to serve as an additional tool for all one hundred counties to be used as guidance and give direction in the event that multiple counties are involved in the provision of services to the same family.
- The Division held the Multiple Response System Conference in Asheville in August, 2007, featuring a wide variety of educational speakers and workshops.
- Transylvania Community Hospital implemented an automated visit history tracking system to enable medical providers to better connect possible patterns of child abuse / neglect.
- The Gun Safety Subcommittee of the NC Child Fatality Task Force is actively working to produce an informational campaign / message to increase the need for gun safety for all children.
- The North Carolina State Child Fatality Prevention Team continues to gather information and advocate for consistent and accurate identification of injuries to children when seen in emergency departments in order to identify patterns of child abuse / neglect.
- Prevent Child Abuse North Carolina, the Division, and local Departments of Social Services continue rigorous campaigns to educate community service providers and public about appropriate safe sleeping.
- The OCME has provided training in multiple counties on Child Death Scene Investigations, and recognizing child abuse / neglect.
- Numerous law enforcement agencies and departments of social services in counties across NC have provided trigger / gun locks to gun owners to prevent children from discharging firearms.
- Prevent Child Abuse NC has provided regional training across NC to assist professionals and public on recognizing and reporting suspected child abuse / neglect.
- The Transylvania County Department of Social Services purchased two simulator infant dolls which DSS staff utilizes with every parent or caretaker on a newborn or infant. This doll is used to help parents / caretakers understand the dangers of shaking or mishandling an infant. Transylvania DSS is also in the process of organizing a community education forum designed to educate the community on both recognizing and reporting child abuse and neglect. Transylvania County DSS has created a CD which covers topics including crying and other normal behaviors of newborns which will be distributed to parents / caretakers of infants. A “baby basket”, which includes information and resources, has also been created for distribution to parents / caretakers of small children. The “Baby Think it Over” Program continues to be taught to 9<sup>th</sup> grade students, and a discussion of Safe Surrender is included in that curriculum.

- Stanly County DSS coordinated and hosted the Child Death Scene Investigation Training which was offered by Lisa Mayhew of the Office of the Chief medical Examiner. This training was made available for DSS staff, law enforcement, first responders, and other community services professionals.
- Craven County has hired a System of Care (SOC) Coordinator who is working to educate the public about how to access mental health services and where to go for appropriate services.
- The Community Child Protection Team is revamping the way local teams look and operate. Work has begun to include more involvement from community members in order to have local teams operate more as CRPs (Community Review Panels) which will allow community members to collaborate with professionals to ensure that children are being protected and services rendered to families as needed.
- The Wilson County CCPT has completed training of 80 people regarding Safe Surrender. They have educated the community on the Safe Surrender protocol through a month long radio ad that informed the public what to do if someone gives you a baby and what to do if you are a teenager who wants to give your baby to someone. They have also been invited by Channel 11 and Channel 17 to do a free advertisement regarding Safe Surrender. They have acquired car seats donated by the Graco Company to use in advertising regarding Safe Surrender and are allowing area agencies and organizations to utilize these car seats in their Safe Surrender advertisements and public education.